STATE OF VERMONT

HUMAN SERVICES BOARD

In re	)	Fair Hearing No. 21,164
	)	
Appeal of	)	

INTRODUCTION

The petitioner appeals a decision by the Department of Aging and Independent Living (DAIL) denying her eligibility for the Choices for Care (CFC) program. The issue is whether the petitioner met the eligibility requirements for the CFC program. The decision is based upon the evidence adduced at hearing and legal memoranda of the parties.

FINDINGS OF FACT

1. The petitioner is a seventy-three-year-old woman. Petitioner receives community based Medicaid and Medicare. Petitioner has a number of pre-existing conditions including dizziness, osteoarthritis, and pain in her back. On or about August 3, 2007, petitioner fell and fractured her left

shoulder. Petitioner applied for CFC coverage on or about August 9, 2007.[1]

2. B.S. is a Long Term Care Clinical Consultant (LTCCC) employed by DAIL; she was assigned the petitioner's case. As part of her job, she conducts a home visit and assesses the level of need an applicant needs with Activities of Daily Living (ADLs). The ADLs include dressing, bathing, personal hygiene, bed mobility, toilet use, adaptive devices, transferring, mobility, and eating.

3. B.S. assessed petitioner on or about September 10, 2007 at the petitioner's home. In petitioner's assessment, B.S. found that petitioner needed extensive assistance with bathing; limited assistance with toileting, bed mobility, dressing and personal hygiene; and supervision with transferring and mobility. In the assessment, B.S. noted that petitioner fell and was diagnosed with a broken arm and dislocated shoulder. In addition, B.S. noted that Medicare could cover the following services for 6 to 12 weeks; bathing, dressing, meal preparation, and medications. B.S. testified that she believes that Medicare would cover

[1] Petitioner first applied for CFC services for the highest needs or high needs group in the spring of 2007. She was denied eligibility in May 2007 but advised that she could apply for the moderate needs group under the CFC program. Petitioner did not appeal that decision and did not apply for the moderate needs group.

portions of home health care based on her prior experience as a nurse and nurse practitioner. She also testified that current CFC recipients receive both Medicare and CFC services; there is no bar to continued receipt of CFC if Medicare becomes available for certain services.

4. B.S. completed a Clinical Eligibility Worksheet. The second question of the worksheet asked whether petitioner's needs can be met by other services or programs. B.S. stated that Medicare could cover the help petitioner needed with her ADLs. At that point, petitioner did not complete the remaining questions in the worksheet.

5. B.S. sent petitioner a Denial on or about September 24, 2007 that petitioner did not meet the clinical criteria for the CFC program.

6. Petitioner appealed and a commissioner's review occurred. The Commissioner upheld the denial on or about October 29, 2007 stating that petitioner did not meet the nursing home level of care. Petitioner went forward with a fair hearing.

7. When petitioner broke her shoulder, petitioner was not able to lift her left arm. As a result, petitioner had difficulty taking care of bathing, dressing, and other daily needs. At the hearing, petitioner testified that her

daughter helped her with her needs and that her shoulder was still sore. Petitioner explained that she was not knowledgeable about the different programs and relied on her daughter to take care of this type of paperwork.

8. Petitioner's daughter, S.D., has been helping her mother with her daily needs such as bathing and dressing since her mother broke her shoulder. S.D. has worked as a personal care attendant for twenty-seven years including as a personal care attendant under the CFC program. At the time of the hearing, S.D. was not working so that she could care for her mother. S.D. testified that it was her understanding that her mother's doctors wanted her mother to have a personal care attendant and that it was her understanding that Medicare paid only for skilled nursing care.

9. Petitioner submitted documentation from her treating doctors, Dr. J.N. and Dr. S.L.[2] Her documentation confirms that petitioner sustained a fractured shoulder in August 2007 and that she needs help with her ADLs. Dr. S.L. noted in a letter dated November 15, 2007 that:

> For many months now she has not had use of her left upper extremity, which has essentially incapacitated

[2] Petitioner also submitted Clinical Assessment of Need for Assistance with ADLs from her doctors at hearing, but there is no documentation or testimony regarding how they came to their assessment in petitioner's case.

> her. The nature of this type of fracture can take many months to heal. And even during the healing process, it is quite common not to be able to use the extremity involved. [Petitioner's] fracture in particular, is taking a very long time to heal. And even with improvements on radiographs and clinical exam, her fracture is still rather precarious and at risk for nonunion and refracture.

Petitioner receives outpatient physical therapy for her shoulder.

10. Subsequent to the hearing, petitioner and S.D. recontacted the Franklin County Home Health Agency on or about December 27, 2007 to discuss Medicare availability. The Agency recommended that petitioner apply for Medicaid LNA services two to three times per week. The notes indicate an agreement between the Agency, petitioner, and S.D. that petitioner does not need skilled nursing care.

ORDER

DAIL's decision is reversed and remanded consistent with the following decision.

REASONS

DAIL operates the Choices for Care (CFC) program through a waiver from the Centers for Medicare and Medicaid Services. The primary goal of the CFC program is to provide individuals who need nursing home level care with a choice of remaining

in the community by providing home health care for Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). CFC Regulations Section I.

The eligibility criteria are set out at CFC Regulations Section IV. DAIL has created three categories of need ranging from highest needs to high needs to moderate needs. This assessment is done by the Long Term Care Clinical Coordinator (LTCCC) after a review of the application and a home visit to assess the type of assistance the individual needs with ADLs and IADLs.

In terms of the High Needs group, CFC Regulation Section IV(B)(2)(b) states:

> Individuals who meet any of the following eligibility criteria shall be eligible for the High Needs group and may be enrolled in the High Needs group:
>
> > i. Individuals who require extensive to total assistance on a daily basis with at least one of the following ADLs:
> >
> > Bathing Dressing
> > Eating Toilet Use
> > Physical Assistance to Walk

Availability of CFC services for the High Needs group is limited by the availability of funds. CFC Regulations Section V(D)(2).

Here, LTCCC B.S. assessed petitioner in her home and found that petitioner needed extensive assistance with

bathing. Based on the above regulation, petitioner would seem to fit the eligibility criteria for the High Needs Group necessitating a further review of the CFC eligibility criteria such as Medicaid eligibility. However, LTCCC B.S. did not reach this step. Instead, she concluded that petitioner was not eligible because of a belief that those services would be covered by Medicare[3] and denied the petitioner's application.

DAIL's argument relies on CFC Regulations Section VI(A)(3) which states:

> Choices for Care shall not provide or pay for services to meet needs that can be adequately met by services available through other sources. This includes but is not limited to private insurance, Medicaid and Medicare.

The above regulation does not support DAIL's argument that the availability of other sources is a bar to eligibility. The above regulation allows DAIL to determine the amount of their obligation to an individual after first subtracting payments or services from other sources. The Board has seen this approach in its review of cases brought by CFC recipients regarding the scope of CFC services; actual

[3] It should be noted that Medicare does not pay for custodial care but will pay for skilled nursing services for homebound individuals. For Medicare Part B, see 42 U.S.C. § 1395n(a)(2)(A) (individual needs skilled nursing care) and § 1395n(a)(2)(F)(definition of homebound); for Medicare Part A, see 42 U.S.C. § 1395f(a)(2)(C). Petitioner's argument regarding the scope of Medicare services is correct, but a full discussion is not necessary for the purposes of this decision.

CFC services are determined after taking into account services or payments through other sources.

In petitioner's case, DAIL should continue with its review including (1) review of any other eligibility criteria, (2) the amount and type of services needed for petitioner's ADLs and IADLs, and (3) what other services are available such as Medicaid LNA services.

Accordingly, DAIL's decision to deny petitioner CFC eligibility as a member of the High Needs group should be reversed and the case should be remanded to allow petitioner's application to be fully considered under the appropriate criteria.

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